

Aug. 14. 2009 4:25PM PRMC Medical Staff Services

No. 7308 P. 11/12

PENINSULA REGIONAL MEDICAL CENTER
AUTHORIZATION AND RELEASE STATEMENT
MEDICAL STAFF

By my signature to this Authorization and Release Statement, I acknowledge the following, where applicable.

In connection with my application for clinical privileges and appointment to the Medical Staff of the Peninsula Regional Medical Center, I acknowledge that I have received and read the Medical Staff Bylaws. I agree to be bound by the terms thereof, whether or not appointed to the Medical Staff or granted clinical privileges.

I understand that I bear the burden of establishing my qualifications and competency in the clinical privileges which I am requesting. I understand that I may be asked to provide information in addition to that which is requested in my application. I recognize that my failure to provide sufficient information to evaluate my application will result in it being deemed incomplete, and that my application will not be processed further. The determination as to whether sufficient information has been submitted will be in the sole discretion of Peninsula Regional Medical Center.

I signify that I am willing to appear for interviews in regard to application, if required.

I authorize Peninsula Regional Medical Center to consult with members of professional and administrative staffs of other hospitals or other institutions with which I have been associated, with any law enforcement agencies, with state licensing bodies and regulatory agencies, with the National Practitioner Data Bank, and with others who may have information regarding my competence, character, and ethical or professional qualifications. I authorize both oral and written communication.

I authorize Peninsula Regional Medical Center to consult with insurance companies that have carried my professional liability insurance concerning my claims history and authorize such carriers to release this information to Peninsula Regional Medical Center.

I give my consent to Peninsula Regional Medical Center's inspection of my records and documents that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges required or moral and ethical qualifications for Medical Staff membership.

I hereby grant a total, complete, unconditional and absolute waiver of any claims, and I release from any and all liability Peninsula Regional Medical Center, all its representatives, and its Medical Staff for their acts performed in connection with the evaluation of my application and credentials.

I hereby grant a total, complete, unconditional and absolute waiver of any claims, and I release from any and all liability all individuals and organizations who provide information to Peninsula Regional Medical Center concerning my competence, ethics, character and other qualifications for Medical Staff appointment, including otherwise privileged or confidential information.

PHOTOSTAT OR OTHER REPRODUCTION OF THIS STATEMENT SHALL BE CONSIDERED VALID.

Sarah C. Aronson, MD

Signature of Applicant

Date

7/27/09

Rev: 11/28/07

